Are Bias, Harassment, and Discrimination by Physician-Peers a Reason Why Some Physicians Leave Rural Communities?

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The challenges of recruiting and, separately, retaining primary care physicians in rural and underserved settings are long-standing, but many of the fundamental factors, forces, and remedies are understood. Primary care physicians are generally drawn (recruited) to rural communities for the lifestyle, the beauty of the countryside and its outdoor activities, and the closeness of the people, in addition to the style of practice and professional challenges there. Many grew up in rural communities, but just as many simply prefer what these communities offer. Many have a personal drive to work in communities with a clear medical need and where the impact of their life’s work can be readily felt. The community, its people, the general feel of the place, and the intimate size of a rural practice and a rural medical community are principal draws.

But too often physicians who set out in rural practice find they are not able to establish positive relationships within the community or otherwise find that they do not fit in. Some experience overt conflicts with the people in their community, in their office, or in the wider medical community. Given the importance of people and relationships to those choosing rural work, when a physician fails to find acceptance, they know they made the wrong choice with this community or practice. They realize they will not find the sense of place and belonging that they came seeking. So they leave, resulting in failed retention.

Ko and Dorri interviewed primary care physicians and others in the rural and agricultural region of California’s central San Joaquin Valley. The authors used clinicians’ own words to identify the types of local interactions that taught some physicians unequivocally and often painfully that they did not fit in. Interviewed physicians who were women, racial/ethnic minorities, and gay, lesbian, bisexual, transgender, or gender nonconforming provided reports of microaggressions, overt insults, harassment, exclusion, and being outed to patients by physicians within their practices or by the wider medical community. Compounding these insults, practice and hospital administrators sometimes failed to acknowledge the sexist, racist, antigay bias, and inflexible gender beliefs underlying these insults, and they sometimes failed to address the transgressions directly with perpetrators or by strengthening antibias polices. Feeling unsupported, the challenged physicians realized there would be no remedy or restitution and the insults would continue. Interviewed physicians directly linked these harassing behaviors from colleagues to their own or other physicians’ decisions to relocate to more accepting practices and communities. With bigotry and too little acceptance and support locally, relationships became unfulfilling, so why stay?

Shouldn’t all physicians show respect and be able to work with peers of any race, sexual orientation, and gender identity? Isn’t this an expectation of the profession? Disappointingly, acceptance of diversity among physician-peers is not addressed in the venerable Hippocratic Oath, the Oath of Maimonides, or the Declaration of Geneva of the World Medical Association, nor in the Medical Board of California’s Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons. To some degree, these oaths, declarations, and regulations speak to a physician’s obligation to treat all patients with dignity and respect, but none address a physician’s obligation to similarly treat all physician-peers with dignity and respect.

The Diversity and Inclusion position statement of the Association of American Medical Colleges explicitly endorses diversity among medical students and physicians as a “driver of excellence,” and the Association of American Medical Colleges helps teaching institutions better support diversity in
the profession. Today's medical students have come of age in a world where diversity and acceptance of differences among peers have been the norm for younger people and are celebrated. Many feel deeply that not accepting others' differences is wrong. In part pushed by these millennials, academic institutions are learning to embrace diversity and incorporate it into expectations of students' professionalism. As today's students become tomorrow's medical leaders, we can anticipate broader acceptance of—indeed, insistence on—diversity among physicians and their employers. Physicians will be better trained to recognize their own biases, their unintended but hurtful microaggressions, and institutional racism. They will accordingly update hospital bylaws, state practice acts, and declarations of ethical expectations of physicians. But this will take time. To this point, it is encouraging that female and Latinx physician-participants in the study by Ko and Dorri4 noted greater acceptance of gender and racial diversity among physicians in their community, and they cited local education initiatives and policy changes to counter bias against these groups. Gay and gender-diverse individuals have only recently gained a measure of acceptance nationally, and acceptance will take longer in traditionally more socially conservative rural communities.6

The many national and state health care organizations and public agencies working to address rural health workforce issues can help to increase awareness and to reduce the retention-harming effects of the mistreatment of nondominant group physicians, ie, those who do not fit perfectly in the "old boys club."4 Virtually every agency and organization in this sphere sponsors or participates in initiatives to help clinicians and health care organizations meet the unique needs and address the social determinants of health of communities and patients of various sociocultural groups. These initiatives can be expanded to address challenges for physicians and other health care professionals who are women, racial/ethnic minorities, or otherwise perceived as different. Through the annual conferences of the National Rural Health Association, National Association of Community Health Centers, National Rural Recruitment and Retention Network (3RNet), and state primary care associations, physician leaders and administrators can be made aware of the problem and its consequences, taught to recognize the issues in their own organizations, and learn of remedies. During site visits, personnel from state offices of rural health can look out for bias and mistreatment of physicians and other health care professionals and help with education and interventions. Interventions will not always be easy, as they need to address the often hidden or deeply held beliefs of some. The restorative justice model is an approach that could be applied. In it, with the help of mediation, physicians would come together, acknowledge their offenses, try to repair any harm done, and build ties to help prevent recurrences.7

The study by Ko and Dorri4 identified the issues of bias and mistreatment of the sizable demographic subgroups of physicians who are newer to rural communities. They revealed how harmful words and deeds can irreparably damage the physician-community relationship and cause physicians to move elsewhere. Through their interviews, we learn that insults made to individual physicians have consequences for physician turnover and can perpetuate clinician shortages.

ARTICLE INFORMATION


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REFERENCES


